VERMONT

Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Xolair~

Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must fax this form to Change Healthcare. Please complete this form in its entirety, and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare Helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
Name: _____
NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#: _____
Date of Birth: _____ Sex: _____
Patient's Phone: _____
Pharmacy Name: _____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

The following MUST be completed for MEDICAL BENEFIT requests:
HCPCS J-code or other code: _____
Administering Provider/Facility: Name_____ NPI#_____ Medicaid ID#_____
Please check box if this drug is being provided under the DVHA's 340B Drug program and requires the TB modifier ☐

Dose: _____ Frequency: _____ Patient weight (kg): _____
Formulation: ☐ vial ☐ prefilled syringe *For approval of prefilled syringe, a clinically compelling reason must be provided detailing why vials cannot be used

Please select diagnosis/indication for use and complete corresponding section of PA form.
*Clinical documentation must be submitted to support information on PA form

☐ **Moderate to Severe Persistent Asthma** ☐ **Chronic Idiopathic Urticaria** ☐ **Nasal Polyps**

Moderate to Severe Persistent Asthma

- Is the member currently smoking? **NO** ☐ **YES** ☐ Quit Date (if applicable) _____
- Is the prescriber an allergist, immunologist, or pulmonologist: **NO** ☐ **YES** ☐
- Medications trialed for a minimum of 3 consecutive months:

Therapy:	Specific Drug:	Reason for discontinuation:	Date:
ICS/LABA Combination Product:	_____	_____	_____
Leukotriene Receptor Antagonist (LTRA):	_____	_____	_____
Long-Acting Bronchodilator (LAMA):	_____	_____	_____

- Does the patient have uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthma at least one a week): **NO** ☐ **YES** ☐ Number of daytime symptom occurrences per week: _____
  Number of nighttime symptom occurrences per week: _____
- Has the patient had 2 or more exacerbations in the previous year despite use of medium-high dose ICS/LABA given in combination with a leukotriene receptor antagonist (LTRA) or long-acting bronchodilator (LAMA): **NO** ☐ **YES** ☐
- Positive test to perennial aeroallergen by a skin or blood test: **NO** ☐ **YES** ☐ **Aeroallergen:** _____
- IgE level ≥ 30 and ≤ 700 IU/ml (ages 12 and older) or ≥ 30 and ≤ 1300 (ages 6 to 11) prior to beginning therapy with Xolair: **NO** ☐ **YES** ☐
- IgE Level: _____ Date obtained: _____

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Renewal Requests for Moderate to Severe Persistent Asthma

(Clinical notes documenting member's response to therapy must be submitted):

- Has the patient continued to receive therapy with an ICS/LABA? **NO** ☐ **YES** ☐
- Does the patient have documented improvement in FEV1 from baseline? **NO** ☐ **YES** ☐
- Does the patient have a decreased frequency of exacerbations or hospitalizations? **NO** ☐ **YES** ☐
- Is there documented evidence of a decreased dose/frequency of oral steroid requirements? **NO** ☐ **YES** ☐
- Is there documented evidence of a decreased dose/frequency of rescue medications? **NO** ☐ **YES** ☐
- Is there a reduction in the signs and symptoms of asthma? **NO** ☐ **YES** ☐
  - Number of daytime symptom occurrences per week: _____
  - Number of nighttime symptom occurrences per week: _____

Chronic Idiopathic Urticaria

- Has the patient trialed any medications for this indication? **NO** ☐ **YES** ☐

	Specific Drug:	**Reason for discontinuation:**	**Date:**
H1 Antihistamine (at double daily dose):	_____	_____	_____
Leukotriene Receptor Antagonist (LTRA):	_____	_____	_____

- Renewal requests for Chronic Idiopathic Urticaria: please include clinical notes documenting response to therapy

Nasal Polyps

- Has the patient trialed any medications for this indication? **NO** ☐ **YES** ☐

Specific Drug:	**Reason for discontinuation:**	**Date:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Will the patient continue therapy with an intranasal corticosteroid? **NO** ☐ **YES** ☐
- IgE Level: _____ Date obtained: _____
- Renewal requests for Nasal Polyps: please include clinical notes documenting response to therapy

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescribers Signature: Date:

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